

Eastern North Carolina Community Health Survey 2018

Welcome to the Community Health Survey for Eastern North Carolina!

We are conducting a Community Health Assessment for your county. This assessment is being undertaken by a partnership of 33 counties, hospitals, health systems, and health departments in Eastern North Carolina. It allows these partners to better understand the health status and needs of the community they serve and use the knowledge gained to implement programs that will benefit the community.

We can better understand community needs by gathering voices from the community. This survey allows community members like you to tell us about what you feel are important issues for your community. We estimate that it will take about 20 minutes to complete this ~60 question survey. Your answers to these questions will be kept confidential and anonymous.

Thank you very much for your input and your time! If you have questions about this survey, please contact Will Broughton at will.broughton@foundationhli.org.

Part 1: Quality of Life

First, tell us a little bit about yourself...

1. Where do you currently live?

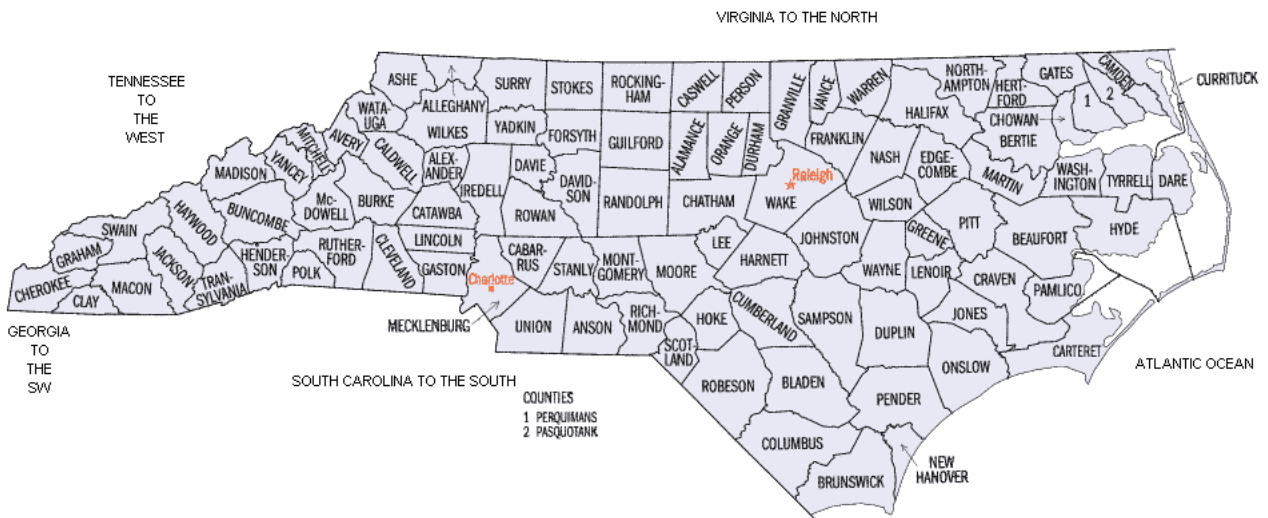
ZIP/Postal Code

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2. What county do you live in?

- | | | |
|-------------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Beaufort | <input type="checkbox"/> Franklin | <input type="checkbox"/> Onslow |
| <input type="checkbox"/> Bertie | <input type="checkbox"/> Gates | <input type="checkbox"/> Pamlico |
| <input type="checkbox"/> Bladen | <input type="checkbox"/> Greene | <input type="checkbox"/> Pasquotank |
| <input type="checkbox"/> Camden | <input type="checkbox"/> Halifax | <input type="checkbox"/> Pender |
| <input type="checkbox"/> Carteret | <input type="checkbox"/> Hertford | <input type="checkbox"/> Perquimans |
| <input type="checkbox"/> Chowan | <input type="checkbox"/> Hoke | <input type="checkbox"/> Pitt |
| <input type="checkbox"/> Cumberland | <input type="checkbox"/> Hyde | <input type="checkbox"/> Sampson |
| <input type="checkbox"/> Currituck | <input type="checkbox"/> Johnston | <input type="checkbox"/> Tyrrell |
| <input type="checkbox"/> Dare | <input type="checkbox"/> Lenoir | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Duplin | <input type="checkbox"/> Martin | <input type="checkbox"/> Wayne |
| <input type="checkbox"/> Edgecombe | <input type="checkbox"/> Nash | <input type="checkbox"/> Wilson |

North Carolina County Map



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3. Think about the county that you live in. Please tell us whether you “strongly disagree”, “disagree”, “neutral”, “agree” or “strongly agree” with each of the next 9 statements.

Statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
There is good healthcare in my County.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This County is a good place to raise children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This County is a good place to grow old.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is plenty of economic opportunity in this County.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
This County is a safe place to live.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is plenty of help for people during times of need in this County.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is affordable housing that meets my needs in this County.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are good parks and recreation facilities in this County.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is easy to buy healthy foods in this County.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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PART 2: Community Improvement

The next set of questions will ask about community problems, issues, and services that are important to you. Remember your choices will not be linked to you in any way.

4. Please look at this list of community issues. In your opinion, which one issue most affects the quality of life in this County? (Please choose only one.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Pollution (air, water, land) | <input type="checkbox"/> Discrimination/ racism | <input type="checkbox"/> Domestic violence |
| <input type="checkbox"/> Dropping out of school | <input type="checkbox"/> Lack of community support | <input type="checkbox"/> Violent crime (murder, assault) |
| <input type="checkbox"/> Low income/poverty | <input type="checkbox"/> Drugs (Substance Abuse) | <input type="checkbox"/> Theft |
| <input type="checkbox"/> Homelessness | <input type="checkbox"/> Neglect and abuse | <input type="checkbox"/> Rape/sexual assault |
| <input type="checkbox"/> Lack of/inadequate health insurance | <input type="checkbox"/> Elder abuse | |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Child abuse | |
| <input type="checkbox"/> Other (please specify) | | |

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5. In your opinion, which one of the following services needs the most improvement in your neighborhood or community? (*Please choose only one.*)

- | | | |
|--|--|---|
| <input type="checkbox"/> Animal control | <input type="checkbox"/> Number of health care providers | <input type="checkbox"/> Positive teen activities |
| <input type="checkbox"/> Child care options | <input type="checkbox"/> Culturally appropriate health services | <input type="checkbox"/> Transportation options |
| <input type="checkbox"/> Elder care options | <input type="checkbox"/> Counseling/ mental health/ support groups | <input type="checkbox"/> Availability of employment |
| <input type="checkbox"/> Services for disabled people | <input type="checkbox"/> Better/ more recreational facilities (parks, trails, community centers) | <input type="checkbox"/> Higher paying employment |
| <input type="checkbox"/> More affordable health services | <input type="checkbox"/> Healthy family activities | <input type="checkbox"/> Road maintenance |
| <input type="checkbox"/> Better/ more healthy food choices | | <input type="checkbox"/> Road safety |
| <input type="checkbox"/> More affordable/better housing | | <input type="checkbox"/> None |
| <input type="checkbox"/> Other (please specify) | | |

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PART 3: Health Information

Now we'd like to hear more about where you get health information...

6. In your opinion, which one health behavior do people in your own community need more information about? (*Please suggest only one.*)

- | | | |
|--|---|---|
| <input type="checkbox"/> Eating well/ nutrition | <input type="checkbox"/> Using child safety car seats | <input type="checkbox"/> Substance abuse prevention (ex: drugs and alcohol) |
| <input type="checkbox"/> Exercising/ fitness | <input type="checkbox"/> Using seat belts | <input type="checkbox"/> Suicide prevention |
| <input type="checkbox"/> Managing weight | <input type="checkbox"/> Driving safely | <input type="checkbox"/> Stress management |
| <input type="checkbox"/> Going to a dentist for check-ups/ preventive care | <input type="checkbox"/> Quitting smoking/ tobacco use prevention | <input type="checkbox"/> Anger management |
| <input type="checkbox"/> Going to the doctor for yearly check-ups and screenings | <input type="checkbox"/> Child care/ parenting | <input type="checkbox"/> Domestic violence prevention |
| <input type="checkbox"/> Getting prenatal care during pregnancy | <input type="checkbox"/> Elder care | <input type="checkbox"/> Crime prevention |
| <input type="checkbox"/> Getting flu shots and other vaccines | <input type="checkbox"/> Caring for family members with special needs/ disabilities | <input type="checkbox"/> Rape/ sexual abuse prevention |
| <input type="checkbox"/> Preparing for an emergency/disaster | <input type="checkbox"/> Preventing pregnancy and sexually transmitted disease (safe sex) | <input type="checkbox"/> None |
| <input type="checkbox"/> Other (please specify) | | |

7. Where do you get most of your health-related information? (*Please choose only one.*)

- | | | |
|---|--|--|
| <input type="checkbox"/> Friends and family | <input type="checkbox"/> Internet | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Doctor/nurse | <input type="checkbox"/> My child's school | <input type="checkbox"/> Help lines |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Hospital | <input type="checkbox"/> Books/magazines |
| <input type="checkbox"/> Church | <input type="checkbox"/> Health department | |
| <input type="checkbox"/> Other (please specify) | | |

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8. What health topic(s)/ disease(s) would you like to learn more about?

9. Do you provide care for an elderly relative at your residence or at another residence? (Choose only one.)

- ☐ Yes
☐ No

10. Do you have children between the ages of 9 and 19 for whom you are the caretaker? (Includes step-children, grandchildren, or other relatives.) (Choose only one.)

- ☐ Yes
☐ No *(if No, skip to question #12)*

11. Which of the following health topics do you think your child/children need(s) more information about? (Check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Dental hygiene | <input type="checkbox"/> Diabetes management | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Reckless |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> STDs (Sexually | driving/speeding |
| <input type="checkbox"/> Fitness/Exercise | Transmitted Diseases) | <input type="checkbox"/> Mental health issues |
| <input type="checkbox"/> Asthma management | <input type="checkbox"/> Sexual intercourse | <input type="checkbox"/> Suicide prevention |
| | <input type="checkbox"/> Alcohol | |
| <input type="checkbox"/> Other (please specify) | | |

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PART 4: Personal Health

These next questions are about your own personal health. Remember, the answers you give for this survey will not be linked to you in any way.

12. Would you say that, in general, your health is... (Choose only one.)

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know/not sure

13. Have you ever been told by a doctor, nurse, or other health professional that you have any of the following health conditions?

	Yes	No	Don't Know
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (not during pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overweight/obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina/heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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14. Which of the following preventive services have you had in the past 12 months? (Check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Mammogram | <input type="checkbox"/> Bone density test | <input type="checkbox"/> Vision screening |
| <input type="checkbox"/> Prostate cancer screening | <input type="checkbox"/> Physical exam | <input type="checkbox"/> Cardiovascular screening |
| <input type="checkbox"/> Colon/rectal exam | <input type="checkbox"/> Pap smear | <input type="checkbox"/> Dental cleaning/X-rays |
| <input type="checkbox"/> Blood sugar check | <input type="checkbox"/> Flu shot | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Blood pressure check | |
| <input type="checkbox"/> Hearing screening | <input type="checkbox"/> Skin cancer screening | |

15. About how long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialists, such as orthodontists. (Choose only one.)

- ☐ Within the past year (anytime less than 12 months ago)
- ☐ Within the past 2 years (more than 1 year but less than 2 years ago)
- ☐ Within the past 5 years (more than 2 years but less than 5 years ago)
- ☐ Don't know/not sure
- ☐ Never

16. In the past 30 days, have there been any days when feeling sad or worried kept you from going about your normal activities? (Choose only one.)

- ☐ Yes
- ☐ No
- ☐ Don't know/not sure

17. The next question is about alcohol. One drink is equivalent to a 12-ounce beer, a 5 ounce glass of wine, or a drink with one shot of liquor.

Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more drinks (if male) or 4 or more drinks (if female) on an occasion?

- | | | | | | | | |
|--|----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 4 | <input type="checkbox"/> 8 | <input type="checkbox"/> 12 | <input type="checkbox"/> 16 | <input type="checkbox"/> 20 | <input type="checkbox"/> 24 | <input type="checkbox"/> 28 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 | <input type="checkbox"/> 9 | <input type="checkbox"/> 13 | <input type="checkbox"/> 17 | <input type="checkbox"/> 21 | <input type="checkbox"/> 25 | <input type="checkbox"/> 29 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 6 | <input type="checkbox"/> 10 | <input type="checkbox"/> 14 | <input type="checkbox"/> 18 | <input type="checkbox"/> 22 | <input type="checkbox"/> 26 | <input type="checkbox"/> 30 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 7 | <input type="checkbox"/> 11 | <input type="checkbox"/> 15 | <input type="checkbox"/> 19 | <input type="checkbox"/> 23 | <input type="checkbox"/> 27 | |
| <input type="checkbox"/> Don't know / not sure | | | | | | | |

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18. Now we will ask a question about drug use. The answers that people give us about their use of drugs are important for understanding health issues in the county. We know that this information is personal, but remember your answers will be kept confidential.

Have you used any illegal drugs within the past 30 days? When we say illegal drugs this includes marijuana, cocaine, crack cocaine, heroin, or any other illegal drug substance. On about how many days have you used one of these drugs? (Choose only one.)

- | | | | | | | | |
|----------------------------|----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 4 | <input type="checkbox"/> 8 | <input type="checkbox"/> 12 | <input type="checkbox"/> 16 | <input type="checkbox"/> 20 | <input type="checkbox"/> 24 | <input type="checkbox"/> 28 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 | <input type="checkbox"/> 9 | <input type="checkbox"/> 13 | <input type="checkbox"/> 17 | <input type="checkbox"/> 21 | <input type="checkbox"/> 25 | <input type="checkbox"/> 29 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 6 | <input type="checkbox"/> 10 | <input type="checkbox"/> 14 | <input type="checkbox"/> 18 | <input type="checkbox"/> 22 | <input type="checkbox"/> 26 | <input type="checkbox"/> 30 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 7 | <input type="checkbox"/> 11 | <input type="checkbox"/> 15 | <input type="checkbox"/> 19 | <input type="checkbox"/> 23 | <input type="checkbox"/> 27 | |
- ☐ Don't know / not sure

(if you responded 0, skip to question #20)

19. During the past 30 days, which illegal drug did you use? (Check all that apply.)

- ☐ Marijuana
- ☐ Cocaine
- ☐ Heroin
- ☐ Other (please specify)

20. During the past 30 days, have you taken any prescription drugs that you did not have a prescription for (such as Oxycontin, Percocet, Demerol, Adderall, Ritalin, or Xanax)? How many times during the past 30 days did you use a prescription drug that you did not have a prescription for? (Choose only one.)

- | | | | | | | | |
|----------------------------|----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 4 | <input type="checkbox"/> 8 | <input type="checkbox"/> 12 | <input type="checkbox"/> 16 | <input type="checkbox"/> 20 | <input type="checkbox"/> 24 | <input type="checkbox"/> 28 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 | <input type="checkbox"/> 9 | <input type="checkbox"/> 13 | <input type="checkbox"/> 17 | <input type="checkbox"/> 21 | <input type="checkbox"/> 25 | <input type="checkbox"/> 29 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 6 | <input type="checkbox"/> 10 | <input type="checkbox"/> 14 | <input type="checkbox"/> 18 | <input type="checkbox"/> 22 | <input type="checkbox"/> 26 | <input type="checkbox"/> 30 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 7 | <input type="checkbox"/> 11 | <input type="checkbox"/> 15 | <input type="checkbox"/> 19 | <input type="checkbox"/> 23 | <input type="checkbox"/> 27 | |
- ☐ Don't know / not sure

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21. The next question relates to veteran's health. Have you ever served on active duty in the US Armed Forces (not including active duty only for training in the Reserves or National Guard)? (Choose only one.)

☐ Yes

☐ No *(if No, skip to question #23)*

22. Has a doctor or other health professional ever told you that you have depression, anxiety, or post traumatic stress disorder (PTSD)? (Choose only one.)

☐ Yes

☐ No

23. Now we'd like to know about your fitness. During a normal week, other than in your regular job, do you engage in any physical activity or exercise that lasts at least a half an hour? (Choose only one.)

☐ Yes

☐ No *(if No, skip to question #26)*

☐ Don't know/not sure *(if Don't know/not sure, skip to question #26)*

24. Since you said yes, how many times do you exercise or engage in physical activity during a normal week?

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25. Where do you go to exercise or engage in physical activity? *(Check all that apply.)*

- | | |
|---|--|
| <input type="checkbox"/> YMCA | <input type="checkbox"/> Worksite/Employer |
| <input type="checkbox"/> Park | <input type="checkbox"/> School Facility/Grounds |
| <input type="checkbox"/> Public Recreation Center | <input type="checkbox"/> Home |
| <input type="checkbox"/> Private Gym | <input type="checkbox"/> Place of Worship |
| <input type="checkbox"/> Other (please specify) | |

Since you responded YES to #23 (physical activity/exercise), skip to question #27.

26. Since you said "no", what are the reasons you do not exercise for at least a half hour during a normal week? You can give as many of these reasons as you need to.

- | | |
|--|---|
| <input type="checkbox"/> My job is physical or hard labor | <input type="checkbox"/> It costs too much to exercise. |
| <input type="checkbox"/> Exercise is not important to me. | <input type="checkbox"/> There is no safe place to exercise. |
| <input type="checkbox"/> I don't have access to a facility that has the things I need, like a pool, golf course, or a track. | <input type="checkbox"/> I would need transportation and I don't have it. |
| <input type="checkbox"/> I don't have enough time to exercise. | <input type="checkbox"/> I'm too tired to exercise. |
| <input type="checkbox"/> I would need child care and I don't have it. | <input type="checkbox"/> I'm physically disabled. |
| <input type="checkbox"/> I don't know how to find exercise partners. | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> I don't like to exercise. | |
| <input type="checkbox"/> Other (please specify) | |

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27. **Not** counting lettuce salad or potato products such as french fries, think about how often you eat fruits and vegetables in an average week.

How many cups per week of fruits and vegetables would you say you eat? (*One apple or 12 baby carrots equal one cup.*)

Number of Cups of Fruit

Number of Cups of Vegetables

Number of Cups of 100% Fruit Juice

28. Have you ever been exposed to secondhand smoke in the past year? (*Choose only one.*)

☐ Yes

☐ No (*if No, skip to question #30*)

☐ Don't know/not sure (*if Don't know/not sure, skip to question #30*)

29. If yes, where do you think you are exposed to secondhand smoke most often? (*Check only one.*)

☐ Home

☐ Workplace

☐ Hospitals

☐ Restaurants

☐ School

☐ I am not exposed to secondhand smoke.

☐ Other (please specify)

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30. Do you currently use tobacco products? (This includes cigarettes, electronic cigarettes, chewing tobacco and vaping.) (Choose only one.)

- ☐ Yes
- ☐ No *(if No, skip to question #32)*

31. If yes, where would you go for help if you wanted to quit? (Choose only one).

- | | |
|--|---|
| <input type="checkbox"/> Quit Line NC | <input type="checkbox"/> Health Department |
| <input type="checkbox"/> Doctor | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Not applicable; I don't want to quit |
| <input type="checkbox"/> Private counselor/therapist | |
| <input type="checkbox"/> Other (please specify) | |

32. Now we will ask you questions about your personal flu vaccines. An influenza/flu vaccine can be a "flu shot" injected into your arm or spray like "FluMist" which is sprayed into your nose. During the past 12 months, have you had a seasonal flu vaccine? (Choose only one.)

- ☐ Yes, flu shot
- ☐ Yes, flu spray
- ☐ Yes, both
- ☐ No
- ☐ Don't know/not sure

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Part 5: Access to Care/Family Health

33. Where do you go most often when you are sick? (Choose only one.)

- | | |
|---|---|
| <input type="checkbox"/> Doctor's office | <input type="checkbox"/> Medical clinic |
| <input type="checkbox"/> Health department | <input type="checkbox"/> Urgent care center |
| <input type="checkbox"/> Hospital | |
| <input type="checkbox"/> Other (please specify) | |

34. Do you have any of the following types of health insurance or health care coverage? (Choose all that apply.)

- ☐ Health insurance my employer provides
- ☐ Health insurance my spouse's employer provides
- ☐ Health insurance my school provides
- ☐ Health insurance my parent or my parent's employer provides
- ☐ Health insurance I bought myself
- ☐ Health insurance through Health Insurance Marketplace (Obamacare)
- ☐ The military, Tricare, or the VA
- ☐ Medicaid
- ☐ Medicare
- ☐ No health insurance of any kind

35. In the past 12 months, did you have a problem getting the health care you needed for you personally or for a family member from any type of health care provider, dentist, pharmacy, or other facility? (Choose only one.)

- ☐ Yes
- ☐ No *(if No, skip to question #38)*
- ☐ Don't know/not sure

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36. Since you said "yes," what type of provider or facility did you or your family member have trouble getting health care from? You can choose as many of these as you need to.

- | | | |
|--|--|---|
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Urgent Care Center |
| <input type="checkbox"/> General practitioner | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Medical Clinic |
| <input type="checkbox"/> Eye care/ optometrist/
ophthalmologist | <input type="checkbox"/> Health department | <input type="checkbox"/> Specialist |
| <input type="checkbox"/> Pharmacy/ prescriptions | <input type="checkbox"/> Hospital | |
| <input type="checkbox"/> Other (please specify) | | |

37. Which of these problems prevented you or your family member from getting the necessary health care? You can choose as many of these as you need to.

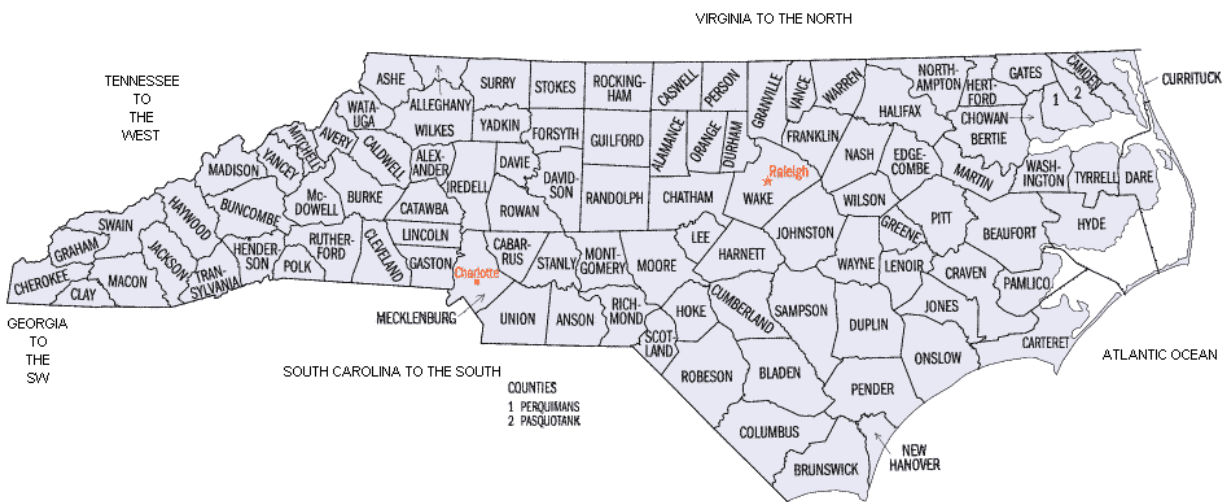
- ☐ No health insurance.
- ☐ Insurance didn't cover what I/we needed.
- ☐ My/our share of the cost (deductible/co-pay) was too high.
- ☐ Doctor would not take my/our insurance or Medicaid.
- ☐ Hospital would not take my/our insurance.
- ☐ Pharmacy would not take my/our insurance or Medicaid.
- ☐ Dentist would not take my/our insurance or Medicaid.
- ☐ No way to get there.
- ☐ Didn't know where to go.
- ☐ Couldn't get an appointment.
- ☐ The wait was too long.
- ☐ The provider denied me care or treated me in a discriminatory manner because of my HIV status, or because I am an LGBT individual.

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38. In what county are most of the medical providers you visit located? *(Choose only one.)*

- | | | | |
|---|------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Beaufort | <input type="checkbox"/> Edgecombe | <input type="checkbox"/> Martin | <input type="checkbox"/> Sampson |
| <input type="checkbox"/> Bertie | <input type="checkbox"/> Franklin | <input type="checkbox"/> Moore | <input type="checkbox"/> Scotland |
| <input type="checkbox"/> Bladen | <input type="checkbox"/> Gates | <input type="checkbox"/> Nash | <input type="checkbox"/> Tyrrell |
| <input type="checkbox"/> Brunswick | <input type="checkbox"/> Granville | <input type="checkbox"/> New Hanover | <input type="checkbox"/> Vance |
| <input type="checkbox"/> Camden | <input type="checkbox"/> Greene | <input type="checkbox"/> Northampton | <input type="checkbox"/> Wake |
| <input type="checkbox"/> Carteret | <input type="checkbox"/> Halifax | <input type="checkbox"/> Onslow | <input type="checkbox"/> Warren |
| <input type="checkbox"/> Chowan | <input type="checkbox"/> Harnett | <input type="checkbox"/> Pamlico | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Columbus | <input type="checkbox"/> Hertford | <input type="checkbox"/> Pasquotank | <input type="checkbox"/> Wayne |
| <input type="checkbox"/> Craven | <input type="checkbox"/> Hoke | <input type="checkbox"/> Pender | <input type="checkbox"/> Wilson |
| <input type="checkbox"/> Cumberland | <input type="checkbox"/> Hyde | <input type="checkbox"/> Perquimans | <input type="checkbox"/> The State of Virginia |
| <input type="checkbox"/> Currituck | <input type="checkbox"/> Johnston | <input type="checkbox"/> Pitt | |
| <input type="checkbox"/> Dare | <input type="checkbox"/> Jones | <input type="checkbox"/> Richmond | |
| <input type="checkbox"/> Duplin | <input type="checkbox"/> Lenoir | <input type="checkbox"/> Robeson | |
| <input type="checkbox"/> Other (please specify) | | | |

North Carolina County Map



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39. In the previous 12 months, were you ever worried about whether your family's food would run out before you got money to buy more? (*Choose only one.*)

- ☐ Yes
- ☐ No
- ☐ Don't know/not sure

40. If a friend or family member needed counseling for a mental health or a drug/alcohol abuse problem, who is the first person you would tell them to talk to? (*Choose only one.*)

- | | |
|--|---|
| <input type="checkbox"/> Private counselor or therapist | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Support group (e.g., AA, Al-Anon) | <input type="checkbox"/> Doctor |
| <input type="checkbox"/> School counselor | <input type="checkbox"/> Pastor/Minister/Clergy |
| <input type="checkbox"/> Other (please specify) | |

41. Does your household have working smoke and carbon monoxide detectors? (*Choose only one.*)

- ☐ Yes, smoke detectors only
- ☐ Yes, both
- ☐ Don't know/not sure
- ☐ Yes, carbon monoxide detectors only
- ☐ No

42. Does your family have a basic emergency supply kit? (These kits include water, non-perishable food, any necessary prescriptions, first aid supplies, flashlight and batteries, non-electric can opener, blanket, etc.)

- ☐ Yes
- ☐ No
- ☐ Don't know/not sure

If yes, how many days do you have supplies for? (Write number of days)

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43. What would be your main way of getting information from authorities in a large-scale disaster or emergency? (Check only one.)

- | | |
|--|--|
| <input type="checkbox"/> Television | <input type="checkbox"/> Social networking site |
| <input type="checkbox"/> Radio | <input type="checkbox"/> Neighbors |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Family |
| <input type="checkbox"/> Telephone (landline) | <input type="checkbox"/> Text message (emergency alert system) |
| <input type="checkbox"/> Cell Phone | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> Print media (ex: newspaper) | |
| <input type="checkbox"/> Other (please specify) | |

44. If public authorities announced a mandatory evacuation from your neighborhood or community due to a large-scale disaster or emergency, would you evacuate? (Check only one.)

- ☐ Yes *(if Yes, skip to question #46)*
- ☐ No
- ☐ Don't know/not sure

45. What would be the main reason you might not evacuate if asked to do so? (Check only one.)

- | | |
|--|--|
| <input type="checkbox"/> Lack of transportation | <input type="checkbox"/> Concern about leaving pets |
| <input type="checkbox"/> Lack of trust in public officials | <input type="checkbox"/> Concern about traffic jams and inability to get out |
| <input type="checkbox"/> Concern about leaving property behind | <input type="checkbox"/> Health problems (could not be moved) |
| <input type="checkbox"/> Concern about personal safety | <input type="checkbox"/> Don't know/not sure |
| <input type="checkbox"/> Concern about family safety | |
| <input type="checkbox"/> Other (please specify) | |

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Part 7: Demographic Questions

The next set of questions are general questions about you, which will only be reported as a summary of all answers given by survey participants. Your answers will remain anonymous.

46. How old are you? (Choose only one.)

- | | | |
|--------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> 15-19 | <input type="checkbox"/> 40-44 | <input type="checkbox"/> 65-69 |
| <input type="checkbox"/> 20-24 | <input type="checkbox"/> 45-49 | <input type="checkbox"/> 70-74 |
| <input type="checkbox"/> 25-29 | <input type="checkbox"/> 50-54 | <input type="checkbox"/> 75-79 |
| <input type="checkbox"/> 30-34 | <input type="checkbox"/> 55-59 | <input type="checkbox"/> 80-84 |
| <input type="checkbox"/> 35-39 | <input type="checkbox"/> 60-64 | <input type="checkbox"/> 85 or older |

47. What is your gender? (Choose only one.)

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Gender non-conforming
- ☐ Other

48. Are you of Hispanic, Latino, or Spanish origin? (Choose only one).

- ☐ I am not of Hispanic, Latino or Spanish origin
- ☐ Mexican, Mexican American, or Chicano
- ☐ Puerto Rican
- ☐ Cuban or Cuban American
- ☐ Other Hispanic or Latino (please specify)

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49. What is your race? (*Choose only one.*)

- ☐ White or Caucasian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Other Asian including Japanese, Chinese, Korean, Vietnamese, and Filipino/a
- ☐ Other Pacific Islander including Native Hawaiian, Samoan, Guamanian/Chamorro
- ☐ Other race not listed here (please specify)

50. Is English the primary language spoken in your home? (*Choose only one.*)

- ☐ Yes
- ☐ No. If no, please specify the primary language spoken in your home.

51. What is your marital status? (*Choose only one.*)

- ☐ Never married/single
- ☐ Married
- ☐ Unmarried partner
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Other (please specify)

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52. Select the highest level of education you have achieved. (Choose only one.)

- ☐ Less than 9th grade
- ☐ 9-12th grade, no diploma
- ☐ High School graduate (or GED/equivalent)
- ☐ Associate's Degree or Vocational Training
- ☐ Some college (no degree)
- ☐ Bachelor's degree
- ☐ Graduate or professional degree
- ☐ Other (please specify)

53. What was your total household income last year, before taxes? (Choose only one.)

- | | |
|---|---|
| <input type="checkbox"/> Less than \$10,000 | <input type="checkbox"/> \$35,000 to \$49,999 |
| <input type="checkbox"/> \$10,000 to \$14,999 | <input type="checkbox"/> \$50,000 to \$74,999 |
| <input type="checkbox"/> \$15,000 to \$24,999 | <input type="checkbox"/> \$75,000 to \$99,999 |
| <input type="checkbox"/> \$25,000 to \$34,999 | <input type="checkbox"/> \$100,000 or more |

54. Enter the number of individuals in your household (including yourself).

55. What is your employment status? (Check all that apply.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Employed full-time | <input type="checkbox"/> Disabled | <input type="checkbox"/> Unemployed for 1 year or less |
| <input type="checkbox"/> Employed part-time | <input type="checkbox"/> Student | <input type="checkbox"/> Unemployed for more than 1 year |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Homemaker | |
| <input type="checkbox"/> Armed forces | <input type="checkbox"/> Self-employed | |

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56. Do you have access to the Internet at home (including broadband, wifi, dial-up or cellular data)? (Choose only one.)

- ☐ Yes
- ☐ No
- ☐ Don't know/not sure

57. (Optional) Is there anything else you would like us to know about your community? Please feel free to tell us below.

[Thank you for your time and participation!](#)

If you have questions about this survey, please contact us at will.broughton@foundationhli.org.